| Patients Name: <Patient Name> | | | | | NHS No: <NHS number> | | | | Livewell | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referral to Plymouth Autism Spectrum Service – Assessment Team | | | | | | | | | | | | | |
| Please note as a specialist led service we require consideration whether there is evidence of Autism. Failure to provide adequate information will result in the referral being returned which will delay the patient care. | | | | | | | | | | | | | |
| Surname: | <Patient Name> | | First Name: | | | | <Patient Name> | | Preferred Name: | | | | <Patient Name> |
| Title: | <Patient Name> | | Date of Birth: | | | | <Date of Birth> | | Marital Status: | | | | <Marital Status> |
| Gender: | <Gender> | | Preferred language: | | | | | | <Main spoken language> | | | | |
| Current address and Postcode | | <Patient Address> | | | | | | Employment status | |  | | | |
| GP Practice & contact number | | <Organisation Details> | | | |
| Phone number | | <Patient Contact Details> | | | | | | Ethnicity | | <Ethnicity> | | | |
| Patient’s mobile phone number | | <Patient Contact Details> | | | | | | Religion | | <Religion> | | | |
|  | | | | | | | | | | | | | |
| Carer/Support worker details (if applicable) | |  | | | | | | Known Allergies: | | <Allergies & Sensitivities> | | | |
| Their Relationship to patient: | |  | | | | | | Reasonable Adjustments required:  I.e., interpreter, easy read info, contact through carer/supporter: | | | | | |
| Contact number: | |  | | | | | |
| Address | |  | | | | | |
| Risks:  Please detail any information or concerns regarding risk (to the individual themselves, or from the individual to others) that we should be aware of prior to an assessment. Do not leave blank.  Please note - we are not able to manage risk while an individual is on our waiting list. If you have concerns, these should be managed by other services/professionals involved in the client’s care. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Referral details: | | | | | | | | | | | | | |
| Referral date & time | | | | <Today's date> | | Referrer name & designation | | | | | <Your Name> | | |
| Referral source | | | |  | | Contact telephone number | | | | | <Organisation Details> | | |
| Has your patient consented to a referral for an Autism Assessment?  Yes  Patient consent is required for referral | | | | | | | | | | | | | |
| Reason for referral: Please provide the following information if known to enable MDT triage. This will enable the PASS-AT MDT to make a good quality decision about your referral  Please briefly outline the reasons for your referral, explaining the impact upon client’s day to day life: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Evidence of Autism: PLEASE NOTE: In order for us to accept a referral for an individual to have an assessment, we must have evidence of possible differences related to the autism spectrum IN BOTH of the areas below. | | | | | | | | | | | | | |
| Social interaction and communication: Please describe, and give examples of, any differences or difficulties relating to social interactions and communication, for example in relation to friendships and relationships; social interactions; understanding others’ emotions and behaviour; verbal and non-verbal communication. Please also include any comments on your experiences of the client’s communication. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Restricted, repetitive patterns of behaviour, interests, or activities:** Please describe, and give examples of, any differences or difficulties relating to restricted or repetitive behaviours or interests, for example in relation to the topic and intensity of interests; routines and rituals; ability to cope with change; repetitive behaviours; rigidity of thoughts or behaviour; sensory sensitivities. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Please X ‘Yes’ or ‘No’** | | | | | | | | | | | | | |
| Is this person a veteran/dependent of? | | | | | | | | | Yes | | | No | |
| Does this person have a child under the age of 1 year? | | | | | | | | | Yes | | | No | |
| Does this person require a diagnosis to access URGENT mental health support? | | | | | | | | | Yes | | | No | |
| Is this person an inpatient? | | | | | | | | | Yes | | | No | |
| Is this person dependent upon drugs or alcohol? | | | | | | | | | Yes | | | No | |
| Other relevant Medical History: | | | | | | | | | | | | | |
| Please provide information about previous/current relevant physical or mental health difficulties: | | | | | | | | | | | | | |
| I am not aware of any relevant physical or mental health difficulties: | | | | | | | | |  | | | | |
| I am aware of the following physical or mental health difficulties**:** | | | | | | | | | | | | | |
| Please refer via e-Referrals: AQ10 assessments are not required to refer to PASSAT  We are unable to manage any mental health needs the client may have whilst they are waiting for an autism assessment. If you think that your client needs support regarding their mental health please ensure they access the appropriate services whilst waiting for an assessment.  We ONLY accept referrals from clinicians (GPs or other professionals) for autism assessments and do not accept self-referrals.  If you have any queries regarding completing this form please email [livewell.PASSAT@nhs.net](mailto:livewell.PASSAT@nhs.net) or phone on: 01752 434034  There is a separate referral form for the PASS Advice Service – available to download from our website below:  [www.livewellsouthwest.co.uk/plymouth-autism-spectrum-service](http://www.livewellsouthwest.co.uk/plymouth-autism-spectrum-service)  We can only accept referrals for clients who:   * Are aged 18 or over * Are registered with a Plymouth GP * Do not already have a diagnosis of an Autism Spectrum Condition * Do not have a diagnosis of Learning Disability * Where there is evidence of difference related to the autism spectrum | | | | | | | | | | | | | |